

VERIFICATION OF UNABLE/UNAVAILABLE STATUS

Client's Name (Last, First, M.I.): _____

Client ID No.: _____ Phone No.: _____

Client's Address (No., Street, City, State, ZIP): _____ Apt #: _____

Child Care Specialist's Name: _____ FAX No.: _____ Phone No.: _____

By signing this form, I authorize the below-named organization or person to release the information requested.

Client's (or Authorized Representative's) Signature: _____ Date: _____

The client listed above has authorized the release of information requested below and requests child care based on their inability or unavailability to provide adequate child care to their child(ren). The information provided will become part of a permanent file with access limited to representatives of DES and the client or the client's authorized representative.

REASON FOR CHILD CARE SERVICES: COMPLETED BY ORGANIZATION OR PERSON PROVIDING INFORMATION

MEDICAL REASONS: Child Care is requested due to a mental, physical, or emotional disability. *(Must be verified by a licensed physician, certified physician assistant, certified nurse practitioner, certified psychologist or behavioral health specialist.)*

1. Patient's Name (First, M.I., Last): _____

2. Prognosis: _____

3. Description of Treatment Plan Needed for Specified Illness:

4. Describe how the medical condition prohibits the patient from caring for their child/children:

5. Date Medical Condition Began: _____ (and) Hours of child care per week needed: _____

6. Enter the Patient's Anticipated Date of Recovery or Next Medical Evaluation Date: _____

NOTE: *When the medical condition is indefinite or lifelong, check here*

This document is valid for one year from the signature date of the approved medical personnel.

DRUG REHABILITATION PARTICIPANT: Child Care is requested due to participation in a drug treatment/rehabilitation program. *(Must be verified by a treatment program counselor or administrator.)*

1. Participant's Name (First, M.I., Last): _____

2. Drug Rehabilitation Participation Schedule: _____

3. Participation Start Date: _____ and Participation End Date: _____

COURT-ORDERED COMMUNITY SERVICE PARTICIPANT: Child Care is requested due to participation in a court-mandated activity. *(Must be verified by a probation officer or court official.)*

1. Participant's Name (First, M.I., Last): _____

2. Participation Start Date: _____ and Participation End Date: _____

PROFESSIONAL PROVIDING INFORMATION

Name (Print or Type): _____

Title: _____ Phone No.: _____

Signature: _____ Date: _____